HOLT FAMILY DENTAL CARE
106 E. WASHINGTON AVE
FAIRFIELD, IOWA 52556
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www.holtfamilydentalcare.com
MICHAEL E. HOLT D.D.S. ***THERESA I. HOLT D.D.S.***

PATIENT INFORMATION (please print)

Name_____ DOB_____
ADDRESS_____
CITY_____STATE_____ZIP CODE_____ SS# _____
EMAIL_____ PHONE#_____ CELL#_____
WORK#_____EMERGENCY CONTACT _____
WHOM MAY WE THANK FOR REFERRING YOU?_____

RESPONSIBLE PARTY

NAME OF RESPONSIBLE PARTY_____
RELATIONSHIP TO PATIENT_____PHONE#_____CELL#_____
ADDRESS_____CITY_____STATE_____
ZIP CODE_____
IS THIS PERSON CURRENTLY A PATIENT? YES NO

PRIMARY DENTAL INSURANCE

NAME OF INSURED_____ _____SS#_____
DOB_____RELATIONSHIP TO PATIENT_____
ADDRESS_____CITY_____STATE_____
NAME OF EMPLOYER_____
EMPLOYER ADDRESS_____CITY_____STATE___
ZIP CODE_____INS. COMPANY NAME_____
INS. COMPANY ADDRESS_____CITY_____STATE_____
INS.ID#_____GROUP#_____INS.CO.PHONE#_____

SECONDARY DENTAL INSURANCE (if applicable)

NAME OF INSURED_____SS#_____
DOB_____RELATIONSHIP TO PATIENT_____
ADDRESS_____CITY_____STATE_____ZIP_____
NAME OF EMPLOYER_____
EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____
INS.CO.ADDRESS_____CITY_____STATE_____ZIP_____
INS. ID#_____GROUP#_____INS.CO.PHONE#_____

Thank you for choosing Holt Family Dental care. We are a family oriented dental office and our patients' dental care is top priority. We do our best to provide information to your dental insurance company regarding your appointments. Please notify us promptly of any changes to your dental insurance and other account information. It is important to have accurate information to avoid any delays in insurance payments.

I understand as a patient or guardian, I am responsible for account balances.

SIGNATURE_____DATE_____

PATIENT MEDICAL HISTORY

PHYSICIAN_____ OFFICE PHONE#_____

DATE OF LAST EXAM_____

Are you currently under care of a physician? **YES NO**

Please explain_____

1. Have you been hospitalized for any surgical procedures/serious illnesses? **YES NO**
2. Are you currently taking any medications, prescription or non prescription? **YES NO**

Please list all medications, vitamins, and supplements_____

_____

3. Do you use tobacco products? YES NO
4. Do you have any ARTIFICIAL JOINTS, IMPLANTS, HEART VALVES, etc? **YES NO**

Please explain_____

_____

5. Have you ever been told to pre-medicate before dental appointments? **YES NO**

If so, with what medication?_____

6. Have you ever had any of the following? **PLEASE CIRCLE ALL THAT APPLY:**

High blood pressure	**Stroke**
Low blood pressure	**Diabetes**
Heart Murmur	**Hepatitis**
Heart disease/Heart Attack	**HIV or AIDS**
Rheumatic Fever	**STD**
Chest pain/Angina	**Cold sores/Fever blisters**
Cancer: type_____	**Radiation therapy**

7. Are you allergic to or had a reaction to any of the following? **PLEASE CIRCLE ALL THAT APPLY:**

Local Anesthetics	**Latex**
Penicillin/other antibiotics	**Codeine**
Aspirin	**Other medications**

Please list other allergies_____ 8.

Women only:

Are you pregnant or think you may be pregnant?	**YES NO**
Are you nursing?	**YES NO**
Do you take medication for Osteoporosis?	**YES NO**

DENTAL HISTORY

Date of last dental exam _____Previous dentist_____

1. Do your gums bleed while flossing?	**YES NO**
2. Are your teeth sensitive to hot, cold, sweet or sour liquids/foods?	**YES NO**
3. Do you feel pain in your teeth?	**YES NO**
4. Do you have any sores or lumps in or near your mouth?	**YES NO**
5. Do you clinch or grind your teeth?	**YES NO**
6. Have you ever had head, neck or jaw injuries?	**YES NO**

I certify that I understand and have answered all the questions to the best of my knowledge.

Signature_____Date_____